



AMERICAN GROUP ADMINISTRATORS, INC.
 101 Convention Center Drive • Suite 200 • Las Vegas, NV 89109

Employee:
 Plan:
 Employee Number:
 D/A:

Dear Mr. OR Mrs.:

Information on your claim form requesting benefits indicates that the expenses resulted in a claim against a third party, and that another person(s) may have been responsible for those injuries.

Your Employee Benefit Plan has a "subrogation" provision that provides for the Plan to be reimbursed for Plan Benefits paid to you or for you when there is a valid and collectable claim against person(s) responsible for those injuries.

Example: You are in a car stopped for a traffic light and are struck by another car from the rear. You are injured and receive medical treatment. The Plan pays \$500.00 of your medical bills. You make a claim against the insurance company of the driver of the other car. You receive a settlement of \$2,000.00. You reimburse the Plan the \$500.00.

However, the Plan has paid your claim pending a successful settlement. *Before any payment can be made, the following statement must be **COMPLETED, SIGNED, NOTARIZED**, and submitted to our office, together with an execution of an assignment to the Plan of all payments made by the Plan to you for which a third party may be responsible.*

I, _____, residing at _____
(street)

_____, _____, _____
(city) (country) (state)

and covered under the above captioned employee benefit plan hereby apply under the Plan for benefits incurred as a result of a claim suffered on _____
(date)

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1) Provide a full description of the claim, including where and how it happened:

2) Name and address of any person(s) you believe responsible for the claim:

3) Name and address of the insurance company of the person(s) responsible for the claim:

4) Name and address of your attorney, if any:

5) Name and address of your auto insurance company:

6) Suit or claim starting date and location of hearing, if any:

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7. () I do not intend to make a claim against the other person(s).
- () I intend to make a claim against the other person(s).
- () I intend to make a direct claim against the other person(s) and do not wish to make a claim under the Employee Benefit Plan at this time.

I certify that the above information is true and complete to the best of my knowledge. I understand that providing false information may lead to a refusal of this claim and **criminal prosecution under the laws of the United States.**

Employee Signature: _____ Date: _____

Patient Signature: _____ Date: _____

November 10, 2006

REIMBURSEMENT AND ASSIGNMENT AGREEMENT

In consideration of payments made, or to be made, to, or on behalf of the participant or the participant's spouse or other dependents, by AMERICAN GROUP ADMINISTRATORS, INC., because of injury/illness sustained from a (an) accident/illness (type) _____ accident/illness, occurring on (date) _____, city _____ state _____, country _____, the undersigned agrees to reimburse the Fund for all such payments made, upon recovery of damages from another person for insurance carrier: I/WE hereby assign to AMERICAN GROUP ADMINISTRATORS, INC., all rights under the PLAN, to the full extent of such payments made. I/WE further agree to do whatever is necessary to enable the FUND to exercise its rights of subrogation, and do nothing to prejudice the FUND from said recover. I/WE also further agree to hold the proceeds of the recovery in trust for the FUND, until such time as reimbursement is made to the FUND.

When delivered to my attorney, _____ will serve as a lien.

Dated this _____ day of _____, 20_____.

Witness:

Participant: _____

Spouse: _____

I HEREBY CERTIFY THAT THE ABOVE NAMED PERSON(S) IS/ARE KNOWN TO ME AND THAT THEY EXECUTED THE FOREGOING DOCUMENT OF THEIR OWN FREE WILL.

Date: _____, 20_____.

Form must be signed, dated and notarized or no benefits are payable.